Prescription Advocates

Welcome to Rx Help Centers

Congratulations! We are thrilled that you have chosen Rx Help Centers as your personal prescription advocate!

Rx Help Centers is proud to work on your behalf to save you money on prescription medicine. We believe that you should be able to receive the medicine you need without creating financial duress. Our programs are designed to give you the most assistance on all of your meds so you can concentrate on living life instead of worrying about money.

HIPAA

In order for us to help you, we will need to have a HIPAA form on file that will allow us to speak with your doctors and prescription manufacturers/grantors. I've attached our HIPAA form to this letter so that you may complete your section and return it to us.

Please, when you're filling out this form, only complete the very top portion, inside the red box, containing PATIENT information and sign the form. The other sections are for Rx Help Centers to complete. We will insert your physician's information and the information of the third party involved (manufacturer/grantor) for each medication that we are helping you with.

If you have any questions, please email us at help@rxhelpcenters.com or call us at 866-478-9593.

If you are a part of the Facebook online community, be sure to become a fan of Rx Help Centers' page www.facebook.com/RxHelpCenters!

Jeff Christensen
President/CEO – Rx Help Centers

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(317) 376-4477 (866) 478-9593
(866) 478-9593 fax

Rx Help Centers
Prescription Advocates

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
SSN #: _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____
Email: _____

Rx Help Centers will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

This authorizes the following medical facility or physician(s): _____

to disclose information as specified below for the following purpose(s): Rx Help Centers will be acting as a prescription advocate for the patient in order to provide assistance with prescribed medications

Rx Help Centers may disclose this information to:

☐ Check if same as above (disclosure to patient)

Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Phone #: ( ) _____ Fax #: ( ) _____
Email: _____

Copies of records or medical record information within the following dates: _____ **to** _____

☐ Both Hospital and Medical Office Records ☐ Medical Office Records ☒ Prescription Records
☐ Records limited to a specific provider: _____ or department: _____
☐ X-Ray films ☐ X-Ray Digital Images ☐ Laboratory Results

NOTE: Hospital and Medical Office records may include disclosure of information related to mental health, alcohol/drug, and HIV references contained within those records as part of this authorization.

The actual treatment records from mental health, or alcohol/drug departments, or results of HIV antibody tests are specifically protected, and will not be disclosed unless you sign below.

Mental Health department records → Signature: _____
Alcohol / Drug dependency treatment records → Signature: _____
HIV antibody test results → Signature: _____

Media Type: ☐ Electronic ☐ Paper **Delivery Preference:** ☐ Email/Secure Portal ☐ Mail ☐ Pickup

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). California recipients are required to obtain your authorization before further disclosing this information.

If you are requesting a form to be completed, we may substitute a standardized version of the form that provides the same or similar information requested.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____
Date Signature If not patient, print your name and relationship

Please submit this form via **Fax: (866) 938-6151** or **Email: billing@rxhelpcenters.com**

Employee ID: _____

Employee Registration

Agent / Agency: RXC8290318	**Agent ID:** -in-mishawaka	**Company:** City of Mishawaka

Internal Use Only

PATIENT INFORMATION

Last Name:		First Name: MI:	
Address:		SS#:	Birthdate:
Address 2:		Gender (circle one): Male Female	
City:		Size of Household:	
State:	Zip:	Annual Household Income:	
Email:		Insurance Carrier:	
Phone:		Medicare D (circle one): Yes No	
Prescriptions (name, dose, frequency, price):		Prescribing Physician (name, address, phone, fax):	

By completing and submitting this form, you agree to allow an Rx Help Centers advocate to contact you regarding your prescriptions. The information that you provide will be used to determine program eligibility and will NOT be distributed to third parties. Once Rx Help Centers begins to advocate on your behalf, you can expect your brand and specialty medications to be approved in as little as 3 weeks. Generics that we assist will be approved in as little as 3 days. This processing time will vary depending on your cooperation and that of the prescribing physician.

Please initial if you understand and agree with the statement above. *

I Agree _____

Patient Signature _____ Date _____

Please submit this form via **Fax: (866) 938-6151** **Email:** billing@rxhelpcenters.com